Regents College Examination Content Guide

Nursing Concepts 3
(Associate Level)

General Description of the Examination

The Nursing Concepts 3 examination measures knowledge and understanding of concepts of nursing care and related nursing actions common to all patients throughout the life cycle, regardless of the health status of the patient. Questions concern nursing problems frequently encountered by the associate degree nurse. Questions are based on the needs of the patient of various age groups and the nursing care actions properly associated with them.

The examination requires students to possess the technical vocabulary and have the knowledge of anatomy and physiology, psychosocial, and physical development, and microbiology generally expected of the associate degree nurse. The examination requires students to demonstrate knowledge of the nursing theoretical framework for each content area as well as the ability to apply this knowledge to nursing practice using the nursing process. In addition, students are required to use critical thinking skills to apply principles, concepts, and theories from the natural and social sciences, and the humanities to the practice of nursing.

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REGENTS COLLEGE EXAMINATIONS

The information in this study guide becomes valid on October 1, 2000.

See p. 32 for information on the Nursing Concepts examination series.

Uses for the Examination

Regents College, the test developer, recommends granting four (4) semester hours of lower-level undergraduate credit to students who receive a score equivalent to a letter grade of C or higher on this examination. This recommendation is endorsed by the American Council on Education. Other colleges and universities also recognize this examination as a basis for granting credit or advanced standing. Individual institutions set their own policies for the amount of credit awarded and the minimum acceptable score. Before taking the examination, you should check with the institution from which you wish to receive credit to determine whether credit will be granted and/or to find out the minimum grade required for credit.

Examination Length and Scoring

The examination consists of approximately 160 four-option multiple-choice questions, some of which are unscored, experimental questions. You will have three (3) hours to complete the examination. Since you will not be able to tell which questions are experimental, you should do your best on all of them. Scores are based on ability level as defined in the item response theory (IRT) method of exam development, rather than simply on your total number of correct answers. Your score will be reported as a letter grade.

Examination Administration

The examination is administered by computer at Sylvan Technology Centers® throughout the United States and in Canada, American Samoa, Guam, Puerto Rico, Saipan (Northern Mariana Islands), and the Virgin Islands. The examination is also administered at approved international testing centers. To receive information concerning testing dates, locations, and fees, contact Regents College.

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Computer-Delivered Testing

If you are testing at a Sylvan Technology Center,® your examination will be delivered by computer. You will enter your answers on the computer using either the keyboard or the mouse.

The system used for our computer-delivered testing is designed to be as user-friendly as possible, even for those with little or no computer experience. Instructions provided on-screen are similar to those you would receive in a paper examination booklet. In addition, before the timed portion of your examination begins, you may choose to complete a tutorial that orients you to the computer testing environment and gives you the opportunity to try each feature before using it in questions that will be scored. You will be instructed in how to use the mouse, the keyboard, and different parts of the screen. We encourage you to take advantage of this tutorial. If you have access to the World Wide Web, you can view the screens that you will see in the tutorial, or actually download a copy of a similar tutorial to practice with, from the Regents College Web site (www.regents.edu).

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Note Concerning Wording of Nursing Diagnoses

The North American Nursing Diagnosis Association (NANDA) continually revises and updates its listing of diagnostic categories, defining characteristics, and etiological factors. For example, between1989 and 1994, the term "potential for" was revised first to "high risk for" and then to "risk for." Questions on the examination that include nursing diagnoses are not intended to test your knowledge of current wording or phrasing. The questions are intended to test your ability to recognize nursing diagnoses that result from nursing assessments. For the purposes of the examination, all diagnoses should be considered correctly worded, even if a newer version of the diagnosis is being used by NANDA.

Content Outline

The major content areas on the examination and the percent of the examination devoted to each content area are listed below.

CONTENT AREA	PERCENT OF THE EXAMINATION
I. Comfort and Pain	10%
II. Human Sexuality	10%
III. Cultural Diversity	10%
IV. Chronic Illness	10%
V. Community-Based Nursing	15%
VI. Needs of the Childbearing Family	25%
VII. Sensory Impairments	10%
VIII. Reproductive Disorders	10%
	100%
Emphasis	
I. Theoretical Framework—Basis for Care	34%
II. Nursing Care Related to Theoretical Framework	66%
	100%

I. Comfort and Pain (10%)

This area focuses on principles related to management of patients' comfort and pain across the life span. Emphasis is placed on the various components of comfort and pain management including pharmacological and nonpharmacological techniques.

A. Theoretical framework: basis for care

1. Types of pain (for example: acute vs. chronic, procedural, postoperative) Characteristics (for example: duration, intensity, onset, location)
2. Physiology of pain
   Gate control theory, pain threshold, neuromodulators of pain (for example: endorphins, enkephalins)
3. Psychology of pain
   a. Cognitive factors (for example: time-limited pain)
   b. Emotional factors (for example: anxiety increases pain, pain threshold, pain tolerance)
   c. Myths about pain (for example: pain is part of aging, pain is part of a hysterical personality, people with chronic pain have hypochondriasis, infants do not feel pain, lack of complaint means the patient is pain free)
4. Suffering (for example: intractable pain, persistent pain)
5. Principles related to the management of comfort and pain (for example: treat before pain becomes severe, use a combination of non-pharmacological and pharmacological approaches, anticipate the need for pain management, administer analgesics around-the-clock rather than as needed)

6. Factors influencing patient's comfort and pain
    a. Sex (for example: differences in ways of expressing pain)
    b. Age/developmental level: neonate through older adults (for example: use age-appropriate pain scales, age-related neurological and cognitive changes, age-related approaches to pain management, recognize patient's inability to verbalize pain)
    c. Individual preferences and patterns (for example: pain relief practices, self-management of pain, past pain experiences)
    d. Physical condition (for example: length of illness, ability to self-manage pain, debilitation, fatigue)
    e. Cultural and spiritual/religious beliefs (for example: stoicism, ceremonies, rituals, meaning of pain, prayer and meditation)
    f. Socioeconomic factors (for example: lack of transportation, costs of medication and equipment, lack of health insurance)
    g. Environmental factors (for example: presence of stairs, seasonal changes, time of day, temperature)
    h. Psychological factors (for example: depression, isolation, powerlessness, anxiety, fear of addiction)
    i. Alternative/complementary treatments (for example: acupuncture, massage, hydrotherapy, aromatherapy, therapeutic touch, humor)
7. Theoretical basis for interventions to promote comfort and relieve pain
    a. Physical modifications (for example: massage, pressure, positioning, backrubs, warm milk, heat or cold, exercise, elevate head of bed, use of pillows, transcutaneous electric nerve stimulation [TENS], time for uninterrupted sleep)
    b. Environmental modifications (for example: assistive devices, room temperature, ventilation, noise reduction)
    c. Psychological modifications (for example: distraction, relaxation techniques, guided imagery, cognitive behavioral therapies, biofeedback, meditation)
    d. Medications (for example: narcotic and nonnarcotic analgesics, sedatives, hypnotics, antidepressants, topicals, World Health Organization [WHO] 3-step ladder approach, nonsteroidal anti-inflammatory medications)
    e. Research findings (for example: music therapy, nurse's bias related to use of pain medications, distraction, postoperative analgesia administration)
    f. Ethical and legal implications (for example: marijuana use, terminal illness and use of narcotics, use of placebos, withholding medications from neonates during surgical procedures)

B. Nursing care related to theoretical framework

1. Roles of the nurse in pain management (for example: provider of care, manager of care, teacher, patient advocate)
2. Assessment: gather and organize data in relation to the patient's comfort and pain
    a. Obtain information about the patient's history related to comfort and pain (for example: verbalization of pain level, pain relief measures, the effects of pain on daily living, past experiences with pain)
    b. Assess factors influencing the patient's comfort and pain (see IA1, IA3, IA4, IA5, IA6, and IA7)
    c. Obtain physical data (for example: vital signs; body position; facial expressions; onset, intensity, duration and location of pain; rate pain on a pain scale)
3. Analysis: in conjunction with the patient and members of the health care team, synthesize data to identify the patient's actual or potential health problem (nursing diagnosis)
    a. Identify nursing diagnoses (for example: chronic pain related

to reduced blood supply to tissues, potential for injury related to the side effects of medication, knowledge deficit related to lack of information on pain relief measures, acute pain related to physical injury, sleep pattern disturbance related to change in environment, fatigue related to sleep pattern disturbances)

b. Set priorities (for example: based on the patient's developmental level, based on sociocultural considerations, based on Maslow's hierarchy of needs, based on individual preference, based on optimal use of resources)

4. Planning: in conjunction with the patient and members of the health care team, determine expected outcomes (patient-centered goals) and formulate specific strategies to achieve the expected outcomes

   a. Establish expected outcomes (patient-centered goals) related to health promotion, health maintenance, and health restoration (for example: patient reports pain level has been decreased to a 3 on a 10-point scale, patient describes positive effects of guided imagery as evidenced by decreased need for medication, patient sleeps 7 hours each night)

   b. Plan nursing measures on the basis of established standards and priorities to help the patient achieve the expected outcomes (patient-centered goals) (for example: use measures to relieve pain such as backrub, distraction, and repositioning; administer analgesics as ordered; reduce environmental distractions such as noise and lighting; apply World Health Organization [WHO] 3-step ladder approach to promote pain relief; comply with *A Patient's Bill of Rights*; comply with the Agency for Health Care Policy Research [AHCPR] management of pain guidelines)

   c. Incorporate factors influencing the patient's comfort and pain in planning the patient's care (for example: consider the patient's usual pain relief measures, consider the patient's cultural and spiritual/religious response to pain) (see IA3, IA5, IA6, and IA7)

   d. Assign patient care activities to other members of the health care team as appropriate (for example: assign nursing assistant to distract patient who is in pain, assign nursing assistant to assist other team members to reposition the patient who is in acute pain)

5. Implementation: initiate and complete nursing plans designed to move the patient toward the expected outcomes (patient-centered goals) related to health promotion, health maintenance, and health restoration

   a. Use nursing measures to promote comfort and reduce pain (for example: administer a backrub, use of heat or cold, positioning, active listening, follow standard protocols, distraction techniques, guided imagery)

   b. Administer prescribed medications (for example: administer pain medication before the pain becomes severe, schedule administration of medications to avoid nocturnal awakenings, schedule pain medication prior to ambulation, consider dosage modifications and drug selection related to the patient's age)

   c. Use technology to moderate pain (for example: transcutaneous electrical nerve stimulation [TENS], nebulizers, patient-controlled analgesia [PCA] pumps, continuous subcutaneous infusion, peripherally inserted central catheters [PIC] lines)

   d. Use nursing measures to modify the environment (for example: eliminate noises, provide music, decrease lighting, eliminate odors, control temperature, provide the appropriate assistive devices)

e. Use nursing measures to promote safety (for example: use of siderails when patient is sedated, teach patient not to operate machinery while on pain medication, position patient to maintain airway)

f. Provide information and instruction regarding comfort and pain relief to patient and significant others (for example: instruct patient about relaxation techniques, instruct patient regarding use of patient-controlled analgesia [PCA], instruct patient in use of transcutaneous electrical nerve stimulation [TENS], modify lifestyle to accommodate pain relief measures)

g. Use nursing resources to promote continuity of care (for example: teaching, referrals, support groups, community resources, pain clinics, American Chronic Pain Association, American Pain Society)

h. Provide information on patient's pain and ability to manage to physicians and other members of the health care team (for example: patient's need for adjustment in medication, method used to manage pain)

6. Evaluation: assess the patient's response to nursing care including progress toward the expected outcomes (patient-centered goals)

   a. Document assessment findings in response to interventions (for example: chart effectiveness of pain intervention, use of pain flow sheets, changes in vital signs, record patient's rating on a pain scale)

   b. Assess and report the patient's response to actions taken to reduce pain (for example: increased activity after application of heat or cold, statements of pain relief after analgesic administration)

   c. Reassess and revise the patient's plan of care as necessary (for example: encourage the patient to request a change in pain medication, revise the teaching plan to include guided imagery when patient does not want to use medications, collaborate with physician on analgesic prescription and administration protocol)

   d. Determine the patient's response to care provided by other members of the health care team (for example: ask nursing assistant to report if ambulation has improved after pain interventions)

II. Human Sexuality (10%)

This area focuses on the understanding of human sexuality as an aspect of holistic health care. Emphasis is placed on the various components of human sexuality as they effect and are affected by illness.

A. Theoretical framework: basis for care

1. Sexuality (definition)—the physical, emotional, and sociocultural factors that affect sexual response.

   a. Developmental factors (for example: female genitalia, breasts, menstrual cycle, menopause; male genitalia, ejaculation, and male menopause; age-related changes such as slower sexual arousal, enlarged prostate, decreased fertility, side effects of medications and illness)

   b. Learning of gender roles (for example: woman may stay at home to raise children and care for household, man may be the provider of income to support the family. In the US, role reversal is more common today.)

   c. Sociocultural factors (for example: women are taught to tolerate sex, women are encouraged to participate in sex, sexual modesty is valued, incest is taboo, women work in nontraditional jobs)

   d. Preferences (for example: contraception; reproductive choice; sex only after marriage; sexual orientation including heterosexual, homosexual, bisexual, and transsexual)

   e. Sexual activity (for example: masturbation; sexual intercourse; oral-genital stimulation; fantasy; stimulation of erogenous zones including lips, ears, skin, thighs, and breasts; celibacy)

f. Cultural and spiritual/Religious beliefs (for example: contraception, termination of pregnancy, monogamous relationship, only female-male coitus is acceptable, no premarital intercourse, modesty, privacy, clothing choices, patterns of touching)

g. Sexual response cycle

1) Excitement (for example: increased heart rate and blood pressure, flushed skin, increased blood flow to the genitals)

2) Plateau (for example: sex flush, vasocongestion of the vagina, secretion from Cowper's glands in the male, increase in length and diameter of the penis)

3) Orgasm (for example: involuntary spasmodic contractions of the genitals, decreased muscular control of arms and legs, altered level of consciousness)

4) Resolution (for example: relaxation, fatigue, fulfillment)

2. Sexual dysfunction

a. Gender-specific problems (for example: female—orgasmic dysfunction, dyspareunia, vaginismus, dryness and decreased elasticity of tissues with menopause; male—impotence, slower arousal, fewer spontaneous erections, premature ejaculation, lessened orgasmic intensity)

b. Age-related changes (for example: chronic diseases, decreased mobility, body image, medications)

3. Sexually transmitted diseases

a. Prevention of sexually transmitted diseases (for example: use of condom, abstinence, testing for HIV infection)

b. Impact of sexually transmitted diseases on sexuality (for example: infertility, cervical carcinoma)

4. Theoretical basis for interventions related to human sexuality

a. Physical manifestations (for example: sexual ambiguity, sexual changes in aging, genetics)

b. Environmental modifications (for example: need for privacy in discussion of sexual concerns)

c. Alternative/complementary therapy (for example: use of massage for sexual stimulation)

d. Psychological manifestations (for example: sexual orientation, comfort with touch)

e. Safety (for example: following safe sex practices, use of birth control measures, methods to prevent rape/sexual assault)

f. Medications (for example: effects of antianxiety agents, antihypertensives, and anti-arrhythmics on sexual response; Viagra; vaginal lubricants)

g. Research findings (for example: research on the patient's preference for nurse to initiate discussion on sexual concerns, patient preference for birth control methods, effective teaching of safe sex practices)

h. Ethical and legal implications (for example: teenage access to birth control measures, sex education in schools, access to rape counseling)

i. Contraception (for example: types of birth control, rationale for use, complications of various methods)

B. Nursing care related to theoretical framework

1. Roles of the nurse in human sexuality (for example: provider of care, manager of care, teacher, patient advocate)

2. Assessment is the process of gathering and organizing data in relation to the patient's health status.

a. Obtain the patient's history

1) Health history (for example: acute or chronic illness, medications, frequency of physical exams, urinary function, lumps, discharge)

2) Conduct an interview on sexual activity (for example: reproductive history, sexual role performance and functioning, sexual identity, birth control practices, family planning measures)

3) Identify sexual self-care behaviors (for example: breast self-examination [BSE], testicular self-examination [TSE], Pap smear, mammogram)

b. Assess factors influencing the patient's sexual history (for example: age of onset of sexual maturity, religion, culture, educational level, socioeconomic status)

c. Obtain objective data (for example: results of Pap smear, mammogram, hormone levels, cultures of discharge, blood tests for sexually transmitted diseases, PSA levels)

d. Identify inappropriate sexual behaviors

1) sexual harassment (for example: unwanted verbal or physical advance, sexually explicit language)

2) sexual abuse (for example: incest, sexual assault/rape of a child or adult)

3) sexually acting out (for example: in residential settings)

e. Review laboratory and other diagnostic data (for example: cultures; blood tests for Venereal Disease Research Laboratory [VDRL], human immunodeficiency virus [HIV], hepatitis B)

3. Analysis: in conjunction with the patient and members of the health care team, synthesize data to identify the patient's actual or potential health problem (nursing diagnosis)

a. Identify nursing diagnoses (for example: altered sexuality pattern related to fear of pregnancy, anxiety related to loss of sexual functioning, fear related to history of sexual abuse, knowledge deficit related to self-care behaviors, pain related to dyspareunia)

b. Set priorities (for example: based on the patient's developmental level, based on sociocultural needs, based on Maslow's hierarchy of needs, based on optimal use of resources)

c. Establish expected outcomes (patient-centered goals) related to health promotion, health maintenance, and health restoration (for example: patient's anxiety will decrease after learning alternative sexual activities, patient will be less fearful after receiving psychological and sexual counseling, patient will demonstrate correct breast self-examination [BSE] procedures, patient will increase comfort level by using different positions during sexual activity)

4. Planning is the process of determining the expected outcomes (patient-centered goals) and formulating specific strategies to achieve the expected outcomes.

a. Using established nursing standards and protocols, plan nursing measures to help the patient (for example: open patterns of communication with patient, Rape Protocols, safe-sex practices, sex education in schools)

b. Consider factors influencing the patient's willingness to work with the health care team (for example: lifestyle, culture, religion, mobility)

c. Incorporate factors influencing the patient's willingness to work with the health care team (for example: encourage participation of the significant other, identify resources for the patient such as free or low-cost clinics, maintain privacy of the hospitalized patient, ask health care provider to decrease dose or change medications which may influence sexual response)

d. Assign patient care activities to other members of the health care team as appropriate (for example: assign patient translator, assign nursing care assistant to report nursing home resident's inappropriate behavior)

5. Implementation: initiate and complete nursing plans designed to move the patient toward the expected outcomes (patient-centered goals) related to health promotion, health maintenance, and health restoration
   a. Use nursing measures to establish a collaborative relationship with the patient (for example: use therapeutic communication skills, identify cultural and individual differences, establish expectations with the patient)
   b. Provide information and instructions regarding self-care behaviors (for example: breast self-examination [BSE], testicular self-examination [TSE], hygiene, provide information and instruction on family planning)
   c. Provide information to correct sexual myths (for example: each person is born with a certain amount of sexual desire, sexual abstinence is necessary for sports training, excessive sexual activity can lead to mental illness, and women should not enjoy sexual activity as much as men)
   d. Use nursing measures to promote continuity of care (for example: teach about American Association of Sex Educators, Women's Health Watch, National Child Abuse Hotline, National Coalition Against Sexual Assault)

6. Evaluation: assess the patient's response to nursing care, including progress toward the expected outcomes (patient-centered goals)
   a. Document and report the patient's response to nursing actions (for example: decreased anxiety, improved level of comfort, understanding of self-care behaviors)
   b. Reassess and revise the patient's plan of care (for example: need to change dose of antihypertensive medication, need for additional counseling, patient's response to post-rape care)
   c. Determine the patient's response to care provided by other members of the health care team (for example: patient understands written information provided by the translator, nursing assistant reports that resident demonstrates less inappropriate sexual behavior)

III. Cultural Diversity (10%)

This area focuses on understanding the impact of the patient's culture on the patient's response to health, illness, care, and the caregivers. This section will focus primarily on the five largest cultural groups in the U.S. today: European Americans, African Americans, Hispanic Americans (Latinas/Latinos), Asian Americans, and Native Americans. Examples of cultural beliefs and practices listed reflect traditional values of the culture. The nurse is responsible for ascertaining the importance of these values to individual patients and their families.

A. Theoretical framework: basis for care

1. Cultural definitions: culture, cultural diversity, and cultural competency
   a. Culture is the way people of a group see the world based on a set of values, beliefs, patterns of behavior, customs, traditions, and language. It is learned and passed from generation to generation.
   b. Cultural diversity is the differences among people of different population groups.
   c. Cultural competency is the ability to recognize and respect cultural differences. It includes an understanding of how culturally based beliefs, values, and attitudes influence one's perception of wellness, illness, and health care. The nurse demonstrates cultural competence by incorporating these cultural beliefs and practices into treatment plans and patient care.

2. Cultural considerations
    a. Ethnicity based on common heritage (for example: same religious practices, political interests, folklore, language, and dialect, and employment patterns)
    b. Race based on specific physical characteristics (for example: skin pigmentation, facial features, and hair texture)
3. Cultural diversity concerns
    a. Stereotyping (for example: all older adults are senile, men never cry, Germans are stoic)
    b. Gender-specific issues (for example: many African Americans and many European Americans identify the female as the main decision maker and dominant figure in the family, Arab Americans identify the male as the dominant figure in the family)
    c. Language and communication (for example: patients who do not speak English, avoiding eye contact or direct eye contact, need for an interpreter)
    d. Socioeconomic factors (for example: poverty, lack of health care, homelessness, poor nutrition, immigration)
    e. Age-related perspectives (for example: many Asian Americans and many Native Americans respect older adults and view them as symbolic leaders, many Hawaiians have a hierarchy of family structure, the increasing incidence of elder abuse in the United States)
    f. Time orientation (for example: for many Native Americans, time is present oriented; for many African Americans, time orientation is not strict)
    g. Personal space (for example: many African Americans stand and sit close when communicating, many Asian Americans and European Americans place distance between self and others when communicating)
    h. Food and nutrition (for example: rice and vegetables are staples of many Asian American diets; many Native Americans and Hispanic Americans eat two meals a day; Jews, Muslims, and Seventh Day Adventists do not eat pork)
    i. Health care (for example: many European American cultures believe that illness has a known cause that can be treated or cured; many other cultures believe that illness has a supernatural cause, illness is a punishment, and that illness occurs when the body's equilibrium is disturbed; many cultures have greater reliance on folk or faith healers, folk remedies)
4. Theoretical basis for intervention related to cultural diversity
    a. Physical manifestations (for example: common physical characteristics, language and ancestry; use of charms and amulets to protect against evil spirits, wearing religious articles such as medals by many Hispanic Americans; use of meditation, exercise to maintain balance by many Asian Americans; use of medicine man by many Native Americans)
    b. Environmental (for example: the patient, family, and community are part of the healing model for some African Americans; use of traditional healing practices such as voodoo practitioners; many Native Americans' perception of time may be different)
    c. Psychological (for example: illness may be seen as a state of disharmony that results from natural causes by some African Americans; wellness is viewed as a reward for good behavior by some Hispanic Americans; maintenance of balance between hot and cold is characteristic of the naturalistic belief system of some Hispanic Americans; illness is thought to be caused by an imbalance between yin and yang by many Asian Americans; Native Americans may believe that health depends on maintenance of equilibrium among the body, mind, and environment)

d. Research (for example: Leininger's theory "Culture Case Diversity and Universality"; personal space requirements of various cultural groups, perceived resistance due to cultural differences, response of native peoples from oral traditions to written materials)

e. Healthy practices (for example: use of traditional herbal remedies only; combined use of ritual and prayer and herbal remedies; some Asians require lower doses of certain drugs to achieve therapeutic serum blood levels)

f. Food preferences (for example: Hispanic American classification of hot and cold foods; use of herbs, religious dietary practices)

B. Nursing care related to theoretical framework

1. Roles of the nurse in cultural diversity (for example: provider of care, manager of care, teacher, patient advocate)

2. Assessment: gather and organize data in relation to the patient's health status

   a. Obtain the patient's health history including a cultural assessment (for example: patient's beliefs about the cause of illness—germ theory, spirits, curses, and punishments)

   b. Assess cultural factors influencing the patient's health status (for example: nutrition including ethnic foods, key family members are involved in health care decisions, healing systems, health habits, lifestyle risks, religious rites, talisman, religious restrictions)

   c. Obtain objective data (for example: cultural preferences during physical assessment including female-male relationships, limiting body exposure; patient who wears amulet, patient with cupping marks)

   d. Review laboratory and other diagnostic data (for example: sickle-cell anemia and hypertension in African Americans, lactose enzyme deficiency and diabetes mellitus in Hispanic Americans, alcoholism and communicable diseases in Native Americans, cardiovascular and gastrointestinal diseases in European Americans)

3. Analysis: in conjunction with the patient and members of the health care team, synthesize data to identify the patient's actual or potential health problems (nursing diagnosis)

   a. Identify nursing diagnoses (for example: impaired verbal communication related to shyness about cultural differences, spiritual distress related to inability to participate in culturally based rituals, ineffective management of therapeutic regime related to mistrust of health care providers, powerlessness related to health care provider's inability to understand significance of dietary and religious beliefs)

   b. Set priorities (for example: based on cultural, social, and religious needs, optimal use of resources, developmental level, and Maslow's hierarchy of needs)

4. Planning: in conjunction with the patient and members of the health care team, determine the expected outcomes (patient-centered goals) and formulate specific strategies to achieve the expected outcomes

   a. Establish expected outcomes (patient-centered goals) related to health promotion, health maintenance, and health restoration (for example: the patient will communicate effectively with the health care team with the use of an interpreter, patient will report enhanced spiritual well-being when use of a spiritual counselor is incorporated into patient care, the patient will identify traditional folk remedies that may be incorporated into the plan of care, the patient will explain important religious and dietary needs to the health care team)

b. Use established nursing standards and protocols, plan nursing measures to help the patient (for example: cultural assessment, holistic health care, health risk appraisal)

c. Consider cultural factors influencing the patient's plan of care (for example: dietary needs, rituals, spiritual advisors, birth attendants, death attendants)

d. Assign patient care activities to other members of the health care team, as appropriate (for example: encourage spiritual advisors to participate in health care decisions, provide privacy for practice of rituals and prayer, involve the dietitian in meeting special needs)

5. Implementation: initiate and complete nursing plans designed to move the patient toward the expected outcomes (patient-centered goals) related to health promotion, health maintenance, and health restoration

   a. Use nursing measures to establish a collaborative relationship with the patient (for example: respect cultural and individual differences, define expectations with the patient, use an interpreter to facilitate communication)

   b. Use nursing measures to enhance patient compliance with the health care team (for example: introduce patient and family to hospital staff and volunteers who are from the same culture, ethnic group, religion; incorporate cultural practices into care as appropriate)

   c. Provide information and instruction regarding health promotion, maintenance, and restoration (for example: impact of dietary practices on healing; interaction of herbal remedies and prescribed medications, develop plan for medication administration that does not interfere with religious practices)

   d. Use nursing measures to promote continuity of care (for example: referrals of patient and staff to The World Health Organization [WHO], International Council of Nurses [ICN], community support groups, and resources such as sources for ethnic foods)

6. Evaluation: assess the patient's response to nursing care including progress toward the expected outcomes (patient-centered goals)

   a. Document and report the patient's response to nursing actions (for example: the patient communicates understanding of treatment plan, the patient and family are compliant with the treatment plan, patient's nutritional intake has improved)

   b. Reassess and revise the patient's plan of care (for example: use visiting nurse for follow-up care, encourage family to bring food from home)

   c. Determine the patient's response to care provided by other members of the health care team (for example: patient's nutritional status improved, patient's spiritual needs are met)

IV. Chronic Illness (10%)

This area focuses on the concept of chronicity and the impact of chronic illness on the patient, family, and community. Chronic illness affects patients across the lifespan and is characterized by periods of exacerbations and remissions.

A. Theoretical framework: basis for care

1. Principles related to chronic illness

   a. Chronic illness trajectory (for example: duration, direction and movement, predictability, shape)

   b. Comparison of acute/chronic illness (for example: incidence, prevalence, duration, exacerbations and remissions)

   c. Adjustment patterns in chronic illness (for example: acceptance of illness, stigma, socialization, use of coping skills and resources)

d. Disability issues (for example: access to health care, discrimination, environmental barriers, correct use of terminology such as a person with a disability rather than a disabled person)

2. Common problems associated with chronic illness
   a. Decreased self-care capacity (for example: patient with hemiplegia, patient with physical limitations, patient experiencing fatigue)
   b. Deterioration and decline of health (for example: patient with progressive oxygenation deficit, patient with progressive neurological disorders)
   c. Issues of quality of life (for example: sexual activity, inability to enjoy life, financial inability to maintain adequate self-care)
   d. Family/caregiver dimensions of chronic illness (for example: caregiver fatigue, lack of caregiver)

3. Factors influencing the patient's adjustment to chronic illness
   a. Sex (for example: caregiver expectations and gender roles)
   b. Age/developmental level: infants through older adults (for example: child with a disability adapts to limitations of the disability easier than an adult who experiences a loss of ability)
   c. Individual preferences and patterns (for example: family response patterns, relationship with health care providers, marriage and family planning)
   d. Physical condition (for example: pain, fatigue, decreased self-care ability, deconditioning)
   e. Cultural and spiritual/religious beliefs (for example: use of religious ritual healing as a belief pattern; cultural interpretation of quality of life; cultural expectation of family members; cultural responses to chronic illness)
   f. Socioeconomic factors (for example: unemployment, low income level, cost of equipment and supplies, family resources, availability of health insurance)
   g. Environmental factors (for example: timing as a care factor, environmental barriers, transportation, occupational hazards, the home setting, availability of respite care)
   h. Psychological factors (for example: emotional balance, denial, anger, depression, regression, stigma, normalization, dissociation, overcompensation, learned helplessness)
   i. Alternative/complementary treatments (for example: massage, stress reduction via biofeedback, herbal medications such as gingko for cognitive loss)

4. Theoretical basis for interventions related to chronic illness
   a. Environmental modifications (for example: durable medical equipment, housing modifications, access ramps)
   b. Safety instruction (for example: functional alterations in activities of daily living, instrumental activities or daily living)
   c. Medications/topical agents (for example: use of chronic pain medications, complex medication routines and issues of compliance, polypharmacy)
   d. Safety devices (for example: use of electronic openers, light clappers, upper mobility braces, automatic lifts, call systems)
   e. Ethical and legal implications (for example: impact of Americans with Disabilities Act [ADA] of 1990, caregiver legitimacy, medical fraud, guardianship, Developmental Disabilities Act [DDA] of 1984, advance directives, do-not-resuscitate [DNR] orders)

B. Nursing care related to theoretical framework

1. Role of nurse in caring for the patient who is chronically ill (for example: provider of care, manager of care, teacher, patient advocate)

2. Assessment: gather and organize data in relation to the patient's chronic illness
   a. Determine the presence of functional ability related to activities of daily living, instrumental activities of daily living, and cognitive ability (for example: cognitive loss as determined by mental status testing, limited upper mobility function as determined by ADL assessment)
   b. Identify patients at risk for physical injury (for example: confused mental state, sensory deficit, weakened physical state)
   c. Determine the patient's position on the chronic illness trajectory (for example: adjustment to chronic illness, body image, self-care, emotional balance, uncertain future)
   d. Assess environmental factors that influence the patient's chronic illness (for example: home and community access, adaptive equipment access, support systems, family response patterns, caregiver and patient's response to health care workers, health care system access, caregiver strain)

3. Analysis: in conjunction with the patient and members of the health care team, synthesize data to identify the patient's actual or potential health problems (nursing diagnosis)
   a. Identify nursing diagnoses (for example: caregiver role strain related to 24-hour care responsibility, feeding self-care deficit related to confusion, altered health maintenance impaired related to decreased mobility, impaired home maintenance management related to lack of motivation)
   b. Set priorities (for example: based on the patient's self-care capacity, based on quality of life, based on access to health care and use of resources)

4. Planning: in conjunction with the patient and members of the health care team, formulate specific strategies to achieve the expected outcomes
   a. Establish expected outcomes (patient-centered goals) for care related to health promotion, health maintenance, and health restoration (for example: patient will verbalize factors that alter chronic pain, caregiver will state plan for respite, patient will identify environmental modifications that will allow for home maintenance behaviors)
   b. Using established nursing standards and protocols, plan nursing measures to help the patient achieve the expected outcomes (patient-centered goals) (for example: monitor patient's rest and activity pattern, refer patient with cognitive impairments to day care, help patient develop a realistic plan for daily activities)
   c. Incorporate factors influencing the patient's environmental safety in planning the patient's care (for example: check equipment for correct function, monitor the patient for cognitive loss, install safety equipment such as handrails on tubs)
   d. Assign patient care activities to other members of the health care team, as appropriate (for example: instruct the home health aide to report changes in the patient's ability to meet activities of daily living)

5. Implementation: carry out nursing plans designed to move the patient toward the expected outcomes (patient-centered goals) related to health promotion, health maintenance, and health restoration
   a. Use nursing measures to establish a collaborative relationship with the patient (for example: use therapeutic communication to discuss patient's attitudes towards receiving help, identify with the patient goals for dealing with presenting symptom)

b. Use nursing measures to structure an environment conducive to safety (for example: suggest the placement of furniture in an uncluttered arrangement, assist family in organizing care routines and obtaining equipment, discuss patient's plan for prioritizing self-care needs)

c. Use nursing measures to promote the resolution of the patient's chronic illness (for example: suggest caregiver support group, guide caregiver through a process of anticipating unpredictable situations)

d. Use nursing measures appropriate to particular safety needs (for example: check caregiver for correct use of turning schedule, assess patient for deconditioning after exacerbation, monitor patient for depression and potential for self-violence)

e. Use safety devices properly (for example: use mobilizing devices correctly, assess caregiver ability to set ventilator settings)

f. Use measures to safely administer medications (for example: assess patient for polypharmacy, set up weekly medication administration system, teach caregiver to give g-tube medications correctly)

g. Provide information and instruction regarding chronic illness (for example: encourage patient to attend self-help classes, encourage caregiver to allow patient to perform self-care)

h. Use nursing measures to promote continuity of care (for example: teaching, referrals, support groups, community resources, obtain listings of subacute facilities in patient's location, refer to self-help groups, advocate for the rights of patients with disabilities)

6. Evaluation: appraise the effectiveness of the nursing interventions relative to the nursing diagnosis and the expected outcomes

   a. Record and report the patient and caregiver's response to nursing actions (for example: patient maintains organized system of care, patient and caregiver stay connected to health care system, patient has less frequent self-reported distressing life events, patient reports increased control over life events)

   b. Reassess and revise the patient's plan of care as necessary (for example: caregiver assumes more decision making as patient's cognitive loss increases, patient revises rest/activity cycle during acute exacerbation)

   c. Determine the patient's response to care provided by other members of the health care team (for example: observe the caregiver perform g-tube flush, determine the caregiver's understanding of medication protocol)

V. Community-based Nursing (15%)

This area focuses on community-based nursing practice. The community is a group, population, or cluster of people with at least one common characteristic (for example: geographic location, occupation, ethnicity, housing condition, shared interests, or work toward common goals.) Community-based nursing focuses on the care of individuals, families, or groups and is designed to increase patient self-care ability and enhance patient decision making. Community-based nursing care is provided in the setting where the patient lives, works, plays, or studies.

A. Theoretical framework: basis for care

1. Defining community, community based care, home care, nurse's role in community settings

   a. Patient focus (for example: individuals, groups, families, populations at risk)

b. Levels of prevention (for example: primary, secondary, tertiary)

c. Practice settings (for example: home, ambulatory care, schools, correctional facilities, residential settings, occupational work sites, shelters, the street)

d. Dimensions of community (for example: location, population, social system)

e. Healthy community (for example: definition, characteristics)

2. Community care systems, policy, and legislation
   a. Global (for example: World Health Organization [WHO] American Red Cross)
   b. National/federal (for example: Medicare, Social Security, Supplemental Security Income, *Healthy People 2000*, Department of Health and Human Services)
   c. State (for example: Medicaid, State Health Department)
   d. Local health department service (for example: level of care, point of service, eligibility of service)

3. Epidemiologic principles that impact on understanding of community-based practice (for example: primary, secondary, tertiary, endemic, epidemic, pandemic, frequency rates, morbidity and mortality rates)

4. Communicable diseases (for example: role in prevention, responsibility when confronted with reportable diseases such as tuberculosis and hepatitis)

5. Factors influencing community-based care
   a. Sex (for example: female and male populations who are at risk)
   b. Age/developmental level: infants through older adults (for example: infant immunizations, toddlers and lead poisoning, school-age children and drugs, adolescent pregnancy, middle-aged adults and hypertension screening, older adults and elder abuse, developmental disabilities)
   c. Family (for example: family violence, divorce, disrupted family, ineffective parenting skills)
   d. Individual factors (for example: educational level, gay/lesbian rights, lifestyle, health habits)
   e. Physical condition (for example: family nutritional status, presence of chronic diseases, substance abuse patterns, maternal-infant health)
   f. Cultural and spiritual/religious beliefs (for example: beliefs about community, expectations of health and illness, spiritual and religious practices)
   g. Socioeconomic factors (for example: income level, access to health care, poverty, legal and illegal immigration patterns)
   h. Environmental factors (for example: overcrowding, unsanitary conditions, pollution, reservoirs of infection, homelessness, home settings, contaminated food, waste disposal, disaster plans)
   i. Psychological factors (for example: chronic mental illness, post-traumatic stress disorder)
   j. Alternative/complementary treatments (for example: use of community-based ethnic healers, lay midwives)

6. Theoretical basis for interventions to promote community-based health care
   a. Medications (for example: direct observation, compliance, teaching)
   b. Maintenance of asepsis (for example: communicable disease control measures, adaptations for home care)
   c. Treatments and procedures (for example: environmental modifications for safe home care, disease reporting, screening)
   d. Dietary modifications (for example: safe handling and preparation of family food, safe water)
   e. Maintenance of environment (for example: unsafe housing, stray animals)

f. Ethical and legal implications (for example: issues of legitimate caregiver roles, undocumented residents and access to health care, the home health visit)

B. Nursing care related to theoretical framework

1. Role of the nurse in the community (for example: provider of care, manager of care, teacher, patient advocate)
2. Assessment: gather and organize data in relation to the family and patient's health status
   a. Determine the family and patient's ability to promote functional health patterns (for example: observe home environment for hazards, assess families ability to access community resources)
   b. Gather home health or community health assessment data (for example: assess handwashing behavior of children in the first grade classroom, assess availability of services for patients with Alzheimer's disease in a given geographic area)
   c. Determine the patient's response to the ongoing home care or community need (for example: observations that indicate patient continues to reside in an unsafe home environment, observations that indicate a group of schoolchildren need more instruction on hygienic practices)
   d. Review laboratory and other diagnostic data (for example: sexually transmitted disease frequency rate, immunization rates, violence rates)
3. Analysis: in conjunction with the patient and members of the health care team, synthesize data to identify the patient's actual or potential health problem (nursing diagnosis)
   a. Identify nursing diagnoses (for example: post-traumatic response to house fire, risk for violence related to sudden loss of income, health seeking behaviors related to concern about environmental condition)
   b. Set priorities (for example: based on the patient's developmental level, based on the access to health care, based on use of resources, based on reimbursement procedures, based on acuity)
4. Planning: in conjunction with the patient and members of the health care team, determine expected outcomes (patient-centered goals) and formulate specific strategies to achieve the expected outcomes (patient-centered goals)
   a. Establish expected outcomes (patient-centered goals) for care related to health promotion, health maintenance, and health restoration (for example: patient will integrate the experience of a house fire in a meaningful way and pursue life goals; family will report involvement in domestic violence support group, group will demonstrate ways to modify the environment)
   b. Using established nursing standards and protocols, plan nursing measures to help the patient achieve the expected outcomes (patient-centered goals) (for example: Standards of Home Health Nursing Practice, family follows immunization schedule for infant follow-up)
   c. Incorporate factors influencing the patient home and community health (for example: family establishes safe hygiene routine to care for a child who has been injured, family reports use of day care center for member with Alzheimer's disease)
   d. Plan for anticipated health care needs based on populations at risk (for example: offer prenatal classes to pregnant adolescents at the local YWCA, teach older adults at the community center about the risk of falls)
   e. Assign patient activities to other members of the health care team as appropriate (for example: send the homemaker to do the shopping, assign the home health aide to bathe the patient)

5. Implementation: initiate and complete nursing plans designed to move the patient toward expected outcomes (patient-centered goals)
    a. Use nursing measures to obtain needed supplies, equipment, and services in the home or community (for example: assist family in selecting durable medical equipment needed for patient care, inform family of services available for child with disabilities, advocate for increased services for people who are homeless)
    b. Maintain aseptic technique (for example: teach caregiver to maintain sterile/clean technique during dressing changes, modify handwashing technique in homes)
    c. Use nursing measures to aid in the resolution of patient needs in home or community (for example: assist family in selecting adult day care for the patient with cognitive loss, ensure safe mobility pattern of patient with sensory deficits who is homebound, inform family of patient who has active tuberculosis to arrange for a follow-up chest X ray)
    d. Administer medications (for example: teach home medication routine to caregiver of toddler with pneumonia, administer immunizations at community sites, consider modifications related to the patient's age)
    e. Provide information and instruction regarding biological safety (for example: instruct family regarding hazards of stray animals, emphasize preventive measures, discuss the spread of infection, refer person who has been abused to domestic violence shelter)
    f. Use nursing measures to promote continuity of care (for example: teaching, referrals, support groups, community resources, teach safe-sex practices to sexually active groups, refer new mother to Special Supplemental Food Program for Women, Infants, and Children [WIC])
6. Evaluation: assess the patient's response to nursing care including progress toward the expected outcomes (patient-centered goals)
    a. Record and report the patient's response to nursing actions (for example: first grade class wash hands correctly after instruction, family misses immunization appointment for newborn, older adult class visits school for socialization activities)
    b. Reassess and revise the patient's plan of care as necessary (for example: reinforce correct sterile dressing technique, revise the teaching plan, follow up with family who missed immunization appointment and plan for future date)
    c. Determine the patient's response to care provided by other members of the health care team (for example: home caregiver is reported for leaving the home of a toddler unattended, patient who is ventilator dependent and homebound indicates the homemaker cleans the house weekly)

VI. Needs of the Childbearing Family (25%)

This area focuses on the nursing care of the childbearing family. Health care needs and problems that occur during the antepartal, intrapartal, postpartal, and neonatal periods are included.

A. Theoretical framework: basis for care of the family

1. The childbearing family
    a. Antepartal period
        1) Signs and symptoms of pregnancy
        2) Physiological changes (for example: uterine growth, cardiovascular changes, respiratory, gastrointestinal/genitourinary [GI/GU] changes, hormonal alterations)

3) Discomforts of pregnancy (for example: morning sickness, urinary frequency, nasal stuffiness, heartburn, backache)

4) Psychosocial changes in the expectant family (for example: emotional responses, role transition, alterations in sexuality, differences based on age and culture, couvade syndrome, emotional responses of extended family)

5) Health maintenance

   a) Mother (for example: calculate estimated date of confinement [EDC]; conception; obstetrical history; lab tests such as serology for syphilis, smear for gonorrhea, tests for chlamydia, HIV, Beta Strep, herpes, Pap smear; patient education regarding nutrition, breast self-examination [BSE], activities of daily living [ADLs], symptoms to be reported, amniocentesis, nonstress test, sonogram)

   b) Fetus (for example: fetal heart rate, fundal height, chorionic villi sampling)

6) Childbirth education (for example: birthing options, childbirth exercises, sibling participation)

7) Complications of pregnancy

   a) Pregnancy-induced complications (for example: gestational diabetes, spontaneous abortion, ectopic pregnancy, pregnancy-induced hypertension [PIH], incompetent cervix, placenta previa, abruptio placenta, preterm labor)

   b) Coexisting medical conditions (for example: diabetes mellitus, anemia, cardiac disease, hypertension, obesity, malnutrition)

   c) Coexisting psychosocial problems (for example: substance abuse, adolescent pregnancy, advanced maternal age, poverty-level income)

8) Medications (for example: prenatal vitamins, magnesium sulfate, ritodrine, terbutaline sulfate [Brethine], iron preparation and docusate sodium [Colace], betamethasone sodium phosphate [Celestone])

9) Medical interventions (for example: fetal monitoring, terbutaline sulfate pumps, blood pressure monitoring)

b. Intrapartal period

   1) Process of labor

      a) True vs. false labor

      b) Onset—lightening, increased show, increased urinary frequency, nesting instinct

      c) Stages and phases of labor, fetal presentation and positions

   2) Complications of labor (for example: fetal malpresentation; pattern of early, late and variable decelerations; primary and secondary inertia; premature rupture of membranes; prolapsed cord)

   3) Medical interventions (for example: amniotomy, episiotomy, induction of labor, forceps, vacuum extraction, cesarean section)

   4) Medications (for example: oxytocics, prostaglandins, anesthesia, analgesics)

c. Postpartal period

1) Anatomical and physiological changes (for example: uterine involution, breast changes, body system changes)

2) Psychosocial adaptation (for example: differentiate between postpartum blues and depression)

3) Role adaptation (for example: mother who works inside the home, single mother)

4) Family planning (for example: adaptations in the postpartum period) (see II)

5) Postpartal complications (for example: hemorrhage, puerperal infections, lacerations, mastitis, cardiac decompensation)

6) Medications (for example: Rh_o(D) immune globulin [RhoGAM], methylergonovine maleate [Methergine], oxytocin [Pitocin], acetaminophen)

7) Teaching (for example: breast-feeding and bottle feeding)

8) Maternal nutrition considerations (for example: lactation, postpartum diet)

9) Self-care activities (for example: lochia, fundal massage, breast care, alterations to exercise, incisional care)

2. Theoretical basis for interventions to promote nursing care for women and newborns (for example: National Association of American Colleges of Obstetricians and Gynecologists [NAACOG], standards for the nursing care of women and the newborn, scope of practice, maternal fetal conflicts, termination of pregnancy issues, advanced maternal age)

B. Nursing care related to theoretical framework: the childbearing family

1. Roles of the nurse in childbearing families (for example: provider of care, manager of care, teacher, patient advocate)

2. Assessment: gather and organize data in relation to the antepartal, intrapartal, and postpartal childbearing family

a. Obtain the patient's health history (for example: obstetric-gynecologic history, expected date of delivery, risk factors, substance abuse [recreational use], fetal movement patterns, current and previous medical-surgical history, medication use)

b. Risk assessment (for example: age, socioeconomic factors, previous birth history, genetic factors, smoking, and drug history)

c. Assess factors influencing the family's response to childbearing (for example: preparation for childbirth, cultural factors, socioeconomic status, age, lifestyle, psychological factors, nutrition, bonding)

d. Obtain physical data (for example: fetal heart rate, fetal movement, weight gain, amount and color of lochia, color of amniotic fluid, location and contraction of the fundus, baseline vital signs, dipstick urine specimen)

e. Review laboratory and other diagnostic data (for example: sonogram, fetal heart monitor, nonstress test, stress test, hemoglobin, hematocrit, white blood cells [WBCs])

3. Analysis: in conjunction with the patient and members of the health care team, synthesize data to identify the patient's actual or potential health problem (nursing diagnosis)

a. Synthesize assessment data (see VIB1)

b. Identify actual or potential nursing diagnoses (for example: fluid volume deficit related to inadequate fluid intake during labor, risk for infection related to episiotomy, urinary retention related to urethral trauma, knowledge deficit related to care of the perineum, altered comfort related to sore nipples, risk for injury related to compromised circulation secondary to pregnancy)

c. Set priorities (for example: based on optimal use of resources, based on patient's development level, based on cultural considerations, based on Maslow's hierarchy of needs)

4. Planning: in conjunction with the patient and members of the health care team, determine expected outcomes (patient-centered goals) and formulate specific strategies to achieve the expected outcomes (patient-centered goals)

   a. Establish expected outcomes (patient-centered goals) for care related to health promotion, health maintenance, and health restoration (for example: patient will correctly demonstrate childbearing exercises, patient will perform care of perineum correctly, patient will demonstrate safe care of infant)

   b. Consider factors influencing the patient's response to childbearing (see VIB1) and involve the patient's family in planning patient care (for example: plan sibling and grandparent visits; consider socioeconomic status in relation to health maintenance; consider ethnicity, age, health care insurance, Medicaid, WIC)

   c. Plan nursing measures on the basis of established standards and priorities to help the family achieve the expected outcomes (for example: referrals, pain protocols, critical pathways, care plans)

5. Implementation: initiate and complete nursing plans designed to move the patient toward the expected outcomes (patient-centered goals) related to health promotion, health maintenance, and health restoration

   a. Use nursing measures to enhance positive outcomes for the childbearing family (for example: provide instruction regarding the effects of nutrition, lifestyle, drugs, medications, and infections; manipulate the environment to foster rest, nutrition, and reduction of stress)

   b. Use nursing measures to promote optimal fetoplacental blood flow (for example: position to prevent vena caval syndrome, provide oxygen and intravenous fluids)

   c. Use nursing measures to ensure a safe environment (for example: safety measures for the patient with preeclampsia, safety measures with use of analgesics)

   d. Use nursing measures to facilitate the progress of labor (for example: positioning, coaching, encourage ambulation, encourage voiding)

   e. Use nursing measures to facilitate involution and healing (for example: episiotomy care, nipple care, fundal massage, breast-feeding)

   f. Use nursing measures to provide emotional support (for example: assist with role transition, foster bonding)

   g. Use nursing measures to ensure optimal nutrition (for example: provide instruction regarding antepartal weight gain, provide postpartal dietary instruction)

   h. Use nursing measures to maintain patient comfort (for example: instruction in breathing patterns, application of heat or cold, small frequent meals, good body mechanics)

i. Use nursing measures specific to prescribed medications during the childbearing cycle (for example: monitor uterine contractions for a patient receiving oxytocin [Pitocin], keep calcium gluconate available for a patient receiving magnesium sulfate, check the blood pressure of a patient receiving ergonovine maleate [Ergotrate], monitor the blood pressure of a patient receiving anesthesia, consider modifications related to the patient's age)

j. Use nursing measures to assist the patient in making educated choices throughout the childbearing cycle (for example: birthing options, family planning)

k. Provide information and instruction (for example: signs and symptoms of impaired involution, self-care needs, infant care, provide information about follow-up care)

l. Use nursing measure to establish a collaborative relationship with the patient (for example: respect cultural differences or differences in child rearing practices, define parenting expectations with patient)

m. Use nursing resources to promote continuity of care (for example: referrals, support groups, community resources)

6. Evaluation: assess the patient's response to nursing care, including progress toward the expected outcome

a. Document assessment findings (for example: chart color and amount of lochia, condition of nipples, condition of episiotomy)

b. Assess and report the patient's response to nursing actions (for example: applications of heat or cold, signs and symptoms of infection, response to pain management, patient's understanding of teaching)

c. Revise the plan of care based on reassessment of patient (for example: change the outcome for a patient who has experienced hemorrhage, administer medication to avoid preterm labor for a patient with placenta previa)

d. Determine family's response to care provided by other members of the health care team (for example: ask questions of the care provider to determine patient's hygienic status)

C. Theoretical framework: basis of care for the neonate

1. The fetus and neonate

a. Conception and implantation

b. Embryonic/fetal development

1) Patterns of development (for example: cephalocaudal, proximodistal)

2) Fetal circulation

c. Diagnostic tests: biophysical profile, amniotic fluid index, amniocentesis, Lecithin/sphingomyelin [L/S] ratio, phenylketonuria [PKU], and Dextrastix)

d. Umbilical cord and placenta

1) Anatomy and physiology (for example: three vessels, Wharton's jelly, cord length)

2) Functions (for example: nutrition, waste elimination, oxygen exchange, endocrine system)

e. Factors influencing fetal growth and well-being (for example: genetic makeup, nutrition, oxygen supply, medications, teratogens, maternal diabetes, maternal substance abuse, condition of placenta)

f. Physiology of the neonate: normal transition to extrauterine life (for example: respiratory changes, circulatory changes, temperature regulation, newborn reflexes, gastrointestinal/genitourinary [GI/GU] function, effect of vaginal delivery vs. cesarean section)

g. Fluid and nutritional needs of the neonate (for example: iron supplements, solid foods, calorie and fluid requirements, breast-feeding vs. bottle feeding, infant feeding behaviors, cultural variations of infant feeding, vitamin K)

h. Complications of the neonate (for example: prematurity, postmaturity, large or small for gestational age, respiratory distress syndrome, hemolytic disease, infection, fetal alcohol syndrome, hypoglycemia, cold stress)

i. Immunizations and medications (for example: vitamin K, hepatitis B, erythromycin eyedrops)

D. Nursing care related to theoretical framework: the fetus and neonate

1. Roles of the nurse in relation to neonates (for example: provider of care, manager of care, patient advocate)

2. Assessment: gather and organize data in relation to the health status of the fetus and neonate

   a. Obtain the fetus/neonate's health history (for example: history of prenatal care, length of gestation, length of labor, type of delivery, maternal history of substance abuse, response to analgesia and anesthesia, knowledge of congenital anomaly, stage of activity, and normal physical findings)

   b. Obtain physical data related to the fetus/neonate's health status (for example: Apgar score, head-to-toe physical assessment, maturity rating)

   c. Review laboratory and other diagnostic data (for example: dextrose heel stick, bilirubin, hematocrit, hemoglobin, white blood cell count [WBCs])

3. Analysis: in conjunction with the patient and members of the health care team, synthesize data to identify the patients' actual or potential health problem (nursing diagnosis)

   a. Synthesize assessment data (see VIC1)

   b. Identify actual or potential nursing diagnoses (for example: ineffective thermoregulation related to newborn transition to the extrauterine environment, ineffective airway clearance related to retained secretions, ineffective infant feeding pattern related to poor sucking reflex)

   c. Set priorities (for example: based on optimal use of resources; patient's development level; Maslow's hierarchy of needs; cultural considerations such as ritual circumcision, use of amulets)

4. Planning: in conjunction with the patient and members of the health care team, determine expected outcomes (patient-centered goals) and formulate specific strategies to achieve the expected outcomes (patient-centered goals)

   a. Establish expected outcomes (patient-centered goals) for care related to health promotion, health maintenance, and health restoration (for example: axillary temperature of neonate will be stable, mother will use the rooting mechanism to initiate feeding, circumcision will show no signs of infection, neonate will demonstrate effective sucking mechanism)

   b. Plan for anticipated needs of the fetus/neonate on the basis of established priorities (for example: plan to facilitate bonding, plan to meet nutritional needs)

   c. Plan nursing measures on the basis of established standards and priorities to help the family achieve the expected outcomes (patient-centered goals) (for example: match baby identification bands with mother's band, swaddle the neonate to promote security and maintain body temperature, increase fluid volume for a neonate who is undergoing phototherapy)

5. Implementation: initiate and complete nursing plans designed to move the patient toward the expected outcome related to health promotion, health maintenance, and health restoration
    a. Use nursing measures to promote a safe environment (for example: provide warmth for the neonate, cover the eyes of a neonate undergoing phototherapy, complete newborn identification procedure, teach use of car seat and safe crib)
    b. Use nursing measures to increase the fetus/neonate's oxygen supply (for example: suction the neonate's airway, administer oxygen at no more than 60%, position neonate on back or side)
    c. Use nursing measures to ensure optimal nutrition (for example: assist with neonate feeding, facilitate breast-feeding, use correct formula)
    d. Use nursing measures to relieve neonatal discomfort (for example: care of circumcision site, comfort crying baby)
    e. Use nursing measures to provide emotional support (for example: foster bonding, swaddle, skin-to-skin contact)
    f. Use nursing measures specific to prescribed medications (for example: administer prophylactic eyedrops, administer phytonadione [Aqua MEPHYTON])
    g. Use nursing measures to facilitate healing (for example: cord care, circumcision care)
    h. Use nursing measures to maintain physiological stability (for example: care during phototherapy, positioning, maintain cord clamp, maintain thermoregulation)
6. Evaluation: assess the patient's response to nursing care, including progress toward the expected outcome (patient-centered goal)
    a. Document assessment findings (for example: daily weight, color and consistency of stool, elevated bilirubin levels)
    b. Assesses neonate's response to nursing actions (for example: response to feeding, bonding, phototherapy)
    c. Revise the plan of care (for example: provide fluid in response to temperature elevation, refer mother to the appropriate agency for follow-up care if the neonate's weight gain is poor, revise the teaching plan)

VII. Sensory Impairments (10%)

This area focuses on the nursing care of patients with sensory dysfunction. Areas include visual, auditory, olfactory, gustatory, tactile, proprioception.

A. Theoretical framework: basis for care

1. Types of sensory alterations
    a. Hearing (for example: otitis media, cerumen impaction, presbycusis, Meniere's disease, labyrinthitis, otosclerosis)
    b. Vision (for example: macular degeneration, cataracts, retinopathy, glaucoma, conjunctivitis, corneal abrasions, retinal detachment, presbyopia, hyperopia, myopia)
    c. Proprioception (for example: gait imbalance, falls)
2. Clinical manifestations of sensory dysfunction
    a. Impaired sensory function (for example: neurovascular deficits, paresthesia, visual impairments, hearing impairments, deafness)
    b. Alterations in comfort (for example: acute and chronic pain)
    c. Alterations in mental status (for example: confusion, slowed thought processes, disorientation)
3. Factors influencing the patient's response to sensory dysfunction
    a. Sex (for example: color blindness)

b. Age (for example: otitis media in younger child, macular degeneration in older adult, strabismus in younger child, otosclerosis in young adult women, genetic abnormalities of vision and hearing in older adults)

c. Psychological factors (for example: stress, sensory deprivation, sensory overload, social isolation, paranoia)

d. Socioeconomic factors (for example: access to health care, access to assistive devices)

e. Environmental factors (for example: sensory overload, sensory deprivation, loud noises, exposure to fumes and toxic substances, improper lighting)

f. Impact of other illness (for example: diabetes mellitus on vision, peripheral vascular disease on proprioception, arthritis on proprioception)

g. Impact of medications (for example: photophobia, ototoxicity, altered taste, altered smell)

4. Theoretical basis for interventions to identify, promote, restore, or maintain sensory function

a. Diagnostic testing (for example: assessment of visual acuity, eye movement, visual fields, opthalmoscopy, tomometry, refraction and accommodations; assessment of auditory acuity; otoscopic examination, Weber test, Rinne test, audiometry, functional hearing and vision assessment)

b. Medications (for example: topical eye analgesics, anti-inflammatory agents, antibiotics, steroids, myotics, mydriatics, osmotic diuretics, decongestants, cerumenolytics, lubricants)

c. Environmental modifications (for example: assistive devices for people with hearing impairments, assistive devices for people with visual impairments, safety devices in the home, use of animals and guides)

d. Preoperative and postoperative care (for example: cataract removal, lens implantation, iridectomy, myringotomy, cochlear implants)

B. Nursing care related to theoretical framework

1. Nurses role with patients with sensory impairments (for example: provider of care, manager of care, teacher, patient advocate)

2. Assessment: gather and organize data in relation to the patient's sensory impairment

a. Gather assessment data

b. Obtain the patient's health history (for example: subjective symptoms, medications, history of trauma, history of infection, allergies, familial and genetic history, onset and duration of symptoms, medical illness, occupation)

c. Assess factors influencing the patient's response to sensory dysfunction (see VIIA3)

d. Obtain physical data related to the patient's sensory dysfunction (for example: pupils equal, round, reactive to light and accommodation [PERRLA]; visual fields test; peripheral challenge test; color correctness test; Weber and Rinne tests; otoscopic exams; touch sensation for sharp and dull; gait and balance tests; Snellen test)

e. Review laboratory and other diagnostic data (for example: audiometry, white blood cells [WBCs], ultrasound of the eye, measurement of intraocular pressure, ophthalmologist exam)

3. Analysis: in conjunction with the patient and members of the health care team, synthesize data to identify the patient's actual or potential sensory impairment (nursing diagnosis)

a. Synthesize assessment data (see VIIB1)

b. Identify actual or potential nursing diagnoses (for example: activity intolerance related to impaired balance and coordination, high risk for injury related to decreased or impaired sensation, risk for trauma related to not using safety glasses, social isolation related to auditory impairment)

c. Set priorities (for example: based on Maslow's hierarchy of needs, based on the patient's developmental level, based on optimal use of resources)

4. Planning: in conjunction with the patient and members of the health care team, determine expected outcomes (patient-centered goals) and formulate specific strategies to achieve the expected outcomes (patient-centered goals)

   a. Establish expected outcomes (patient-centered goals) for care related to health promotion, health maintenance, and health restoration (for example: the patient will modify environment to avoid injury, the patient will demonstrate self-care behaviors following postoperative cataract surgery, the patient will initiate conversation, patient will use hearing aids daily)

   b. Consider factors influencing the patient's response to sensory dysfunction in planning patient care (see VIIA3)

   c. Plan nursing measures on the basis of established priorities to help the patient achieve the expected outcomes (patient-centered goals) (for example: patient washes hands prior to administering eye medications, patient learns to lip read)

   d. Assign patient activities to other members of the health care team as appropriate (for example: assign nursing assistant to help a patient whose vision is impaired, assign LPN/LVN to assist patient to insert hearing aids)

5. Implementation: process of initiating and completing nursing actions/interventions designed to move the patient toward expected outcomes (patient-centered goals) related to health promotion, health maintenance, health restoration

   a. Use nursing measures to protect the patient (for example: teach a patient who is visually impaired to ambulate safely, keep the environment clutter free, assist the patient who is hearing impaired in obtaining assistive devices, assist patient with vertigo with ambulation)

   b. Use nursing measures to promote, maintain, or restore the patient's sensory functioning and/or prevent complications (for example: administer prescribed eyedrops to a patient with glaucoma, position patient to facilitate postmyringotomy drainage, irrigate ears for cerumen impaction)

   c. Use nursing measures to minimize patient discomfort (for example: administer decongestant, lubricants, administer pain medications following surgery, teach patient to correctly apply contact lenses)

   d. Use nursing measures specific to prescribed medications (for example: administer antibiotics for otitis media and conjunctivitis, observe for change in pupil size after administering myotics, administer anti-glaucoma medications, gently pull down on lower lid and have patient look up when administering eyedrops)

   e. Use nursing measures to enhance communication (for example: enhance spoken voice, directly face the patient when communicating, make sure assistive devices are in place, encourage use of assistive devices)

f. Provide information and instruction (for example: instruct the patient in the use of safety glasses, instruct the caregiver on pre- and postoperative care, instruct the patient about the medication regimen, instruct the patient regarding the use of community resources, instruct the patient regarding the use of assistive devices, emphasize the need for follow-up care, reinforce rehabilitation instruction)

g. Use nursing measures to promote continuity of care (for example: teaching, referrals, support groups, community resources, guide dog foundation for the blind, AT&T National Relay center, Lions Club)

6. Evaluation: assess the patient's response to nursing care including progress toward the expected outcomes (patient-centered goals)

   a. Document assessment findings (for example: the patient is more alert and initiates conversation, self-care behaviors, patient cannot respond to spoken word, color selection not appropriate)

   b. Assess and report the patient's response to nursing actions relative to the expected outcomes (patient-centered goals) (for example: patient is free from pain, patient verbalizes the need for follow-up care, patient verbalizes the need to take medication at the prescribed time, patient reports hearing improved after cerumen disimpaction)

   c. Revise the patient's plan of care as necessary (for example: following unsuccessful ear irrigation, request cerumenolytics; revise care plan to provide social activities for the patient who is hearing impaired)

   d. Determine the patient's response to care provided by other members of the health care team (for example: observe husband administer eyedrops to wife after cataract surgery, ask the patient who is visually impaired to demonstrate how the physical therapy assistant taught the use of a cane)

VIII. Reproductive Disorders (10%)

This area focuses on the impact of female and male reproductive disorders on the patient's health. Emphasis is placed on the management of the disorder including surgical, pharmacological, and non-pharmacological techniques.

A. Theoretical framework: basis for care

1. Normal female reproductive function (for example: female hormones, menarche, menstrual cycle, menopause)

2. Normal male reproductive function (for example: male hormones, spermatogenesis, male climacteric, male menopause)

3. Hormonal and structural alterations (for example: hysterectomy, hormone replacement therapy [HRT], atrophic vaginitis, endometriosis, benign prostatic hypertrophy)

4. Clinical manifestations of hormonal and structural alterations (for example: abnormal bleeding, changes in urination, recurrent infections, pruritus, menstrual abnormalities, prolapses, urinary retention, stress incontinence, pelvic pain)

5. Factors influencing the patient's response to hormonal and structural alterations

   a. Age (for example: atrophic vaginitis in the woman who is postmenopausal, pre- vs. postmenopausal hysterectomy)

   b. Individual preferences or patterns (for example: hormone replacement therapy, selection of hygiene products, use of alcohol and tobacco)

   c. Physical condition (for example: diabetes, atrophic vaginitis, cancer treatment, genetic predisposition)

   d. Cultural and spiritual/religious beliefs (for example: female or male circumcision, sterilization, contraception)

   e. Socioeconomic factors (for example: access to health care, nutrition, access to bathing facilities)

f. Environmental factors (for example: exposure to heat, chemicals, radiation)

g. Psychological factors (for example: domestic violence and abuse, mood changes with decreased hormone production)

h. Alternative therapies (for example: use of dong quai for menopause, use of soy, relaxation therapy, massage therapy)

6. Theoretical basis for interventions to promote, restore, or maintain hormonal and structural integrity

a. Medications (for example: antihypertensives, steroids, chemotherapeutics, hypoglycemics, hormones)

b. Activity and positioning (for example: Kegel exercises, limiting activity postoperatively, early ambulation)

c. Assistive devices (for example: penile implants and pumps, pessaries, scrotal supports)

d. Patient monitoring (for example: sanitary pad counts, incision inspection, intake and output, laboratory values)

e. Preoperative and postoperative care (for example: transurethral resection of the prostate, hysterectomy, dilatation and curettage, anterior-posterior colporrhaphy, hydrocelectomy, orchiopexy)

B. Nursing care related to theoretical framework

1. Nurse's role in caring for patients with reproductive disorders (for example: provider of care, manager of care, teacher, patient advocate)

2. Assessment is the process of gathering and organizing data in relation to the patient's health status

a. Obtain the patient's health history (for example: childhood diseases, allergies, major illnesses, medications, menstrual cycles, past surgical procedures)

b. Obtain the patient's sexual history (for example: self-perception, voiding disturbances, fertility management, sexually transmitted diseases, changes in libido, impotence, abortion, gynecological and obstetrical history)

c. Assist with physical examination and diagnostic testing (for example: pelvic examination, laparoscopy, digital rectal examination, testicular examination)

d. Assess factors influencing the patient's reproductive disorder

1) Stress and activity

2) Physical disease processes (for example: diabetes mellitus, hypertension)

3) Use of medication (for example: antihypertensives, steroids, chemotherapeutics, hypoglycemics)

4) Occupation and environment (for example: exposure to chemicals, heat, hormones, radiation)

5) Habits (for example: use of alcohol, tobacco, and illicit drugs; multiple partners)

6) History of domestic violence and abuse

e. Obtain objective data (for example: clinical manifestations, vital signs)

f. Review laboratory and other diagnostic data (for example: ultrasonography, magnetic resonance imaging, cultures, biopsy, mammography, prostate specific antigen [PSA], complete blood cell count, hormone studies)

3. Analysis: in conjunction with the patient and members of the health care team, synthesize data to identify the patient's actual or potential health problems (nursing diagnosis)

a. Identify nursing diagnoses (for example: fear related to alterations in sexual functioning, acute pain related to tissue trauma secondary to surgery, knowledge deficit related to medical treatment, ineffective individual coping related to effects of PMS, body image disturbance related to altered sexual relations with partner)

b. Set priorities (for example: based on the patient's developmental level, based on individual preference, based on Maslow's hierarchy of needs, based on optimum use of resources)

4. Planning: in conjunction with the patient and members of the health care team, determine expected outcomes (patient-centered goals) formulating specific strategies to achieve the expected outcomes (patient-centered goals)

   a. Establish expected outcomes (patient-centered goals) related to health promotion, health maintenance, and health restoration (for example: patient will state that pain has been relieved; patient will be able to discuss fears and concerns; patient will understand disease, manifestations, and medical treatment as evidenced by patient comments; patient will cope effectively with PMS and its manifestations as evidenced by patient comments; patient will verbalize and demonstrate acceptance of self after hysterectomy)

   b. Plan nursing measures to help the patient achieve the expected outcomes (for example: monitor the patient's vital signs, allow the patient to talk about feelings and experiences, teach the patient about medications and assistive devices)

   c. Incorporate factors influencing the patient's psychosocial aspects in planning the patient's care (for example: consider the patient's spiritual, religious, and cultural responses; allow patient to express concerns regarding role performance and self-esteem)

   d. Assign patient care activities to other members of the health care team as appropriate (for example: have nursing assistant report sanitary pad count, ask home health care aide to assess urinary drainage of patient following prostate surgery)

5. Implementation: initiate and complete nursing plans designed to move the patient toward expected outcomes (patient-centered goals) related to health promotion, health maintenance, and health restoration

   a. Use nursing measures to promote comfort (for example: use bland skin cream and lotions to prevent dryness of skin, administer analgesics for pain, actively listen and provide support during the grieving process, monitor continuous bladder irrigation, monitor for urinary retention after catheter removal, use water-soluble vaginal lubricants, perineal hygiene, daily bathing, clean after each voiding and defecation)

   b. Administer prescribed medications (for example: administer pain medications before pain becomes severe, schedule administration of medications to prevent nocturnal awakenings, administer hormone replacement therapy according to regimen, administer oral contraceptives the same time every day, teach the patient or caregiver to administer pain medications, teach the patient the therapeutic effects and side effects of medications)

   c. Use nursing measures to modify the environment (for example: provide privacy to allow open expression of feelings, use room deodorizers to control odors)

   d. Provide information and instruction regarding health maintenance (for example: instruct patient about breast-self examination [BSE] techniques; instruct patient about testicular self-examination [TSE] techniques; instruct patient in perineal exercises; instruct patient about yearly gynecological examinations; instruct patient in

lifestyle factors that affect health maintenance, such as smoking, diet, exercise; avoid straining during defecation; teach patient about drugs that alter sexuality)

e. Use nursing measures to promote continuity of care (for example: referral to counseling or support groups such as RESOLVE)

6. Evaluation: assess the patient's response to nursing care including progress toward the expected outcomes (patient-centered goals)

   a. Document assessment findings and response to interventions (for example: patient demonstrates adequate coping mechanisms, patient verbalizes the need for psychological follow-up care, patient demonstrates no signs of inflammation, patient verbalizes dietary restrictions, patient asks questions about diagnoses and treatment available, patient verbalizes activities that produce the Valsalva effects, patient produces clear urinary output in relation to intake, condition of wound, patient reports reduced level of stress)

   b. Revise the plan of care as necessary (for example: encourage increased fluid intake for urine that is concentrated and bloody; postmenopausal patient selects alternative measures such as diet, vitamins, and exercise to control symptoms in place of hormone replacement therapy; patient reports an increase in pain and discomfort; patient develops an elevated temperature and pulse; patient demonstrates dysfunctional grieving)

   c. Determine the patient's response to care provided by other members of the health care team (for example: ask patient if nursing assistant provided perineal care, determine patient's understanding of use of penile pumps as directed by physician)

Sample Questions

The questions that follow illustrate those typically found on this examination. These sample questions are included to familiarize you with the type of questions you will find on the examination. The answers can be found on the inside back cover of this guide.

1. The nurse charts "complains of continuous abdominal pain in incisional area, rates pain as an 8 on 1 to 10 scale." Which characteristic of pain is omitted from this note?
   1) duration
   2) intensity
   3) location
   4) onset

2. By which mechanism do noradrenergic drug agonists relieve pain?
   1) interruption of the pain signal at the peripheral level
   2) inhibition of pain signal relay across the neuronal synapses
   3) blockage of ion channels in the neurolemma
   4) modulation of the ascending pain signal from the dorsal horn

3. Which observation indicates that the analgesic administered postoperatively to a seven-year-old child is effective?
   The child
   1) talks with a visitor and smiles.
   2) plays a video game on the television.
   3) tells his parent that he feels better.
   4) sips on clear fluids and ice pops.

4. A patient reports difficulty achieving and sustaining erections. It is important for the nurse to ask the patient which question?
   1) "Have you been getting too much exercise?"
   2) "How high is your cholesterol level?"
   3) "Have you been checked for diseases such as diabetes?"
   4) "Do you understand the normal sexual response cycle?"

5. Which diagnostic test provides a definitive diagnosis for a female patient who presents with symptoms of gonorrhea?
   1) rapid plasma reagin (RPR)
   2) darkfield examination of exudate
   3) Pap smear
   4) culture of cervical discharge

6. Which is a nursing priority for a patient in the acute phase of the rape trauma syndrome?
   The nurse
   1) provides effective counseling.
   2) collects appropriate evidence.
   3) establishes a safe environment.
   4) creates a trusting relationship.

7. Which nursing action demonstrates cultural competence in patient care?
   The nurse
   1) treats older patients in a similar manner.
   2) maintains direct eye contact with patients.
   3) provides an interpreter for patients who do not speak English.
   4) accepts health care decisions from the patient.

8. A Native American patient is admitted to the hospital with a rash, cough, and fever. Which is the most important information for the nurse to gather from the nursing assessment?
   The patient's
   1) use of alcohol
   2) employment status
   3) food preferences
   4) immunization history

9. As the patient advocate, the nurse should make which of the following a priority action in the care of a chronically ill patient?
   1) Support the patient's family in their decisions about how they will care for the patient.
   2) Ensure the patient's access to knowledge and respectful treatment.
   3) Provide the patient with information about advance directives.
   4) Educate the family and the patient about how to meet the patient's care needs.

10. Which action should the nurse include in the plan of care to enable patients with a chronic illness to develop a realistic plan for daily living?
   1) Refer patients to the closest agency providing home health care.
   2) Assist patients in setting priorities for important self-care activities.
   3) Assign family members responsibility for assisting with specific needs.
   4) Explain to patients that they will not be able to live life as they did previously.

11. Which is a goal of *Healthy People 2000*: *National Health Promotion and Disease Prevention Objectives?*

    In the United States,
   1) a list of community resource referrals will be developed.
   2) health care for populations will be equalized.
   3) accidental injuries will be eliminated.
   4) the use of computerized diagnostic tools will be improved.

12. Which resource best provides for the immediate safety of battered women?
   1) halfway houses
   2) shelters
   3) missions
   4) respite centers

13. What is the priority diagnostic category for a home care hospice patient?
   1) altered bowel elimination
   2) altered nutritional status
   3) self-care deficit
   4) anticipatory grieving

14. Which is a positive sign of pregnancy?
   1) auscultation of fetal heart tones
   2) elevation of basal body temperature
   3) maternal perception of fetal movement
   4) absence of menses for two consecutive months

15. Why should a patient who is trying to get pregnant be advised to stop smoking before conceiving?
   1) Smoking causes thinning of the bronchial walls.
   2) Smoking increases perinatal loss.
   3) Smoking decreases mucus production.
   4) Smoking is associated with uterine fibroid formation.

16. Which observation of a patient during the second stage of labor indicates that delivery is imminent?
   1) The patient pushes with each contraction.
   2) The fundus rises above the umbilicus.
   3) The fetal head is crowning.
   4) The contractions become shorter.

17. A postpartum patient whose breasts are engorged is having difficulty breast-feeding her neonate. Which nursing action should facilitate the feedings?
   1) Teach the patient to express some milk manually before each feeding.
   2) Allow the patient to substitute formula until the engorgement subsides.
   3) Provide the patient with a nipple shield and instructions for its use.
   4) Instruct the patient to roll each nipple between her thumb and forefinger.

18. Which normal physiological change occurs during the antepartal period of pregnancy?
    1) decreased tidal volume
    2) decreased heart rate
    3) increased blood volume
    4) increased urinary output

19. Which neonatal system is affected when kernicterus results from untreated hyperbilirubinemia?
    1) cardiovascular
    2) gastrointestinal
    3) nervous
    4) respiratory

20. Which factor can cause a neonate to develop hemorrhagic disease?
    1) genetic predisposition
    2) immune system disorder
    3) hemolysis of red blood cells
    4) absence of intestinal flora

21. Which clinical manifestation should the nurse expect when assessing a patient with a retinal detachment?
    1) flashing lights
    2) periorbital edema
    3) purulent discharge
    4) profuse tearing

22. Which is a clinical manifestation of a bulging tympanic membrane?
    1) drainage
    2) pain
    3) tinnitus
    4) vertigo

23. An older adult patient who takes a multivitamin and aspirin daily is experiencing tinnitus. What should the nurse suspect as the cause of this condition?
    1) niacin toxicity
    2) hypotension
    3) salicylate toxicity
    4) middle-ear infection

24. A woman has been diagnosed as having endometriosis. What is the pathological process that occurs with this disease?
    1) The uterine endometrium and underlying muscle tissue are infected.
    2) The uterine lining, the fallopian tubes, and the ovaries are atrophied.
    3) Multiple fibrotic tumors develop in the uterus and around the cervix.
    4) Endometrial tissue proliferates on abdominal organs and support structures.

25. A woman who is postmenopausal is considering estrogen replacement therapy. An increase in which serum laboratory data contraindicates therapy?
    1) blood urea nitrogen
    2) cholesterol
    3) creatinine
    4) bilirubin

26. The nurse assesses a woman following a total abdominal hysterectomy. The nurse notes the following patient data: 45 years old, 195 lb, height 5'3", stopped taking oral contraceptives two weeks ago, smokes three to four cigarettes per day. Based upon the data, which intervention is a priority for this patient?
    1) Put the ordered compression stockings on the patient as soon as possible.
    2) Encourage the patient to begin drinking at least 2,000 mL of water a day.
    3) Allow the patient to rest for as long as possible.
    4) Monitor the patient's vital signs more frequently than the stated standard protocol.

Study Materials

The study materials listed on the following pages are recommended by the examination development committee as the most appropriate resources to help you study for the examination. Those listed as Recommended Resources are essential to your understanding of the content. The Additional Resources may provide clarification for some of the topics on the content outline, or provide enrichment in areas of interest.

This examination is one of seven (7) written examinations required of students in the Regents College associate degree programs in nursing:

Nursing Concepts 1
Nursing Concepts 2
Nursing Concepts 3
Differences in Nursing Care: Area A (modified)
Differences in Nursing Care: Area B
Differences in Nursing Care: Area C
Occupational Strategies in Nursing

Important: The examinations in Commonalities in Nursing Care: Areas A and B will be withdrawn after September 30, 2000, and the examination in Differences in Nursing Care: Area A will exist in a modified form only through September 30, 2001, after which it will be replaced with Nursing Concepts 4. Students in the Regents College AAS(n) and AS(n) degree programs who have not completed Commonalities A and B and Differences A by September 30, 2000 will be required to complete Nursing Concepts 1, 2, and 3 and the modified Differences A—and enroll by February 1, 2001—to use any old-series examinations toward completion of their degree. The current examination in Differences B will be replaced in October 2001 by Nursing Concepts 5, and the examinations in Differences C and Occupational Strategies will be replaced in October 2002 by Nursing Concepts 6 and 7.

If you are planning to take several of the associate degree nursing examinations, you will need to begin building a library of nursing textbooks. For this examination, you should obtain one textbook from each of the following nursing practice areas: community-based nursing, fundamentals, medical-surgical nursing, maternal-newborn nursing, nursing diagnosis, nutrition, pediatrics, and pharmacology. The nursing faculty recommend that you also obtain a good medical dictionary. In addition, textbooks in anatomy and physiology and microbiology will supplement your study. You may want to arrange to have access to textbooks in these areas.

The Regents College Bookstore stocks the current editions of the recommended textbooks for all examinations. In some cases, current editions will be more recent than those listed in this guide. The Bookstore also offers resources in areas such as study strategies, personal planning, and stress reduction. See the separate flyer for further information about purchasing textbooks or other resources through the Bookstore.

You may also find textbooks in college libraries, schools of nursing, medical schools, and hospitals. Public libraries may have some of the textbooks or may be able to obtain them through an interlibrary loan program.

You should allow sufficient time to obtain resources and to study before taking the examination.

Electronic Peer Network

Enrolled Regents College students are eligible to join the Regents College Electronic Peer Network (EPN). The EPN is a Web-based environment that enables Regents College students to interact academically and socially. As an EPN member, you will be able to locate a study partner, join an online study group for your exam, chat in real-time with other students, and access other resources that may be helpful to students preparing for Regents College Examinations. Enrolled students can join the EPN by visiting the Regents College home page and clicking on Electronic Peer Network.

Online Study Services

Regents College online study services provide enrolled and prospective students with access to subject matter experts. These services are available on a fee-for-service basis and currently assist students with writing and statistics. Please email requests for more information about these services to the appropriate address: rcwrite@regents.edu or rcstats@regents.edu or call Learning Services at 888-647-2388 (press 1-4-4 at the greeting). You may email suggestions for new online study services to rclearn@regents.edu.

Virtual Library

The Regents College Virtual Library (RCVL) is an online library designed for distance learners. The RCVL (http://www.library.regents.edu) provides access to a variety of resources such as journal articles, books, Web sites, databases, and reference services. These resources can help you prepare for Regents College Examinations. While some library services are restricted to enrolled students, many are not. To access the RCVL, visit the Regents College home page.

Recommended Resources

Textbooks

The examination development committee strongly recommends that you obtain one textbook in each of the eight areas listed below for use in preparing for the examination. Each of the textbooks provides in-depth exploration of the material in the content areas to be tested. In addition, most of them have a companion study guide. If you would like assistance in organizing your study and reviewing the material in the textbooks, the committee recommends that you consider purchasing the study guides as well.

The recommended textbooks and their companion study guides are listed below. Accompanying each entry is a brief description of the materials. This may assist you in deciding which of the materials to obtain. You do not need to purchase two textbooks in an area. You may prefer a certain author or prefer the way in which the material is presented. When two textbooks are listed, either of them will meet your study needs. If you encounter topics in the content outline that are not covered in the textbook you are using, you should supplement your study with another textbook.

Community-Based Nursing

Ayers, M., Bruno, A.A., & Langford, R.W. (1999). *Community-based nursing care: Making the transition.* St. Louis: Mosby.

This text presents an introduction to community-based nursing and the competencies and tools of community-based nursing. It also presents the care of special populations in the community. The text includes learning objectives for each chapter, critical thinking exercises, and application exercises. Ten cards to guide assessment in the clinical area are included in the textbook.

Fundamentals

Kozier, B., Erb, G., Berman, A., & Burke, K. (2000). *Fundamentals of nursing: Concepts, process, and practice* (6th ed.). Upper Saddle River, NJ: Prentice Hall.

This textbook addresses a wide variety of contemporary fundamental nursing principles under major section headings, such as health beliefs and practices, nursing process, lifespan development, assessing health, integral components of client care and promoting both physiologic and psychological health. Special features of this textbook include a focus on critical thinking, sample nursing care plans, clinical guidelines, and critical pathways.

Study Guide:

Van Leuven, K. (2000). *Study guide for Fundamentals of Nursing: Concepts, process, and practice*. (6th ed.). Upper Saddle River, NJ: Prentice Hall.

Medical-Surgical Nursing

Smeltzer, S,. & Bare, B. (2000). *Brunner and Suddarth's Textbook of medical-surgical nursing* (9th ed.). Philadelphia: Lippincott.

This textbook makes extensive use of diagrams, charts, tables, colored photographs, and nursing care plans to present information. Each chapter begins with a series of learning objectives and a glossary of terms, then proceeds with a review of the physiology and pathology, clinical manifestations, and nursing management. Each chapter concludes with a critical thinking exercise related to the content presented. Interspersed throughout each chapter are discussions about important considerations on gerontological issues and community-based care. The use of color in chapter readings and tables makes this a very usable reference. Included with the text is a self-study disk that offers several different ways to evaluate your learning.

OR

Monahan, F.D., & Neighbors, M. (1998). *Medical-surgical nursing: Foundations for clinical practice* (2nd ed.). Philadelphia: W.B. Saunders

This textbook presents content in logically paired chapters. The chapters related to nursing's knowledge base begin with a review of the anatomy and physiology of the system affected, then present the clinical manifestations of the various problems. A separate chapter on the nursing care of patients with these conditions is presented. The text uses color to highlight important headings and includes colored diagrams and charts. Tables listing common procedures and patient education highlights are included. Clinical pathways and clinical thinking exercises are also included. A series of questions for review appears at the end of each chapter. A companion guide entitled A practical guide to medical-surgical nursing in the home is available.

Maternal-Newborn Nursing

Dickason, E., Silverman, B.L., & Kaplan, J. (1998). *Maternal-infant nursing care* (3rd ed.). St. Louis: Mosby.

OR

Olds, S., London, M.L., & Ladewig, P. (2000). *Maternal newborn nursing: A Family-centered approach* (6th ed.). Upper Saddle River, NJ: Prentice Hall.

Nursing Diagnosis

Wilkinson, J.M. (1996). *Nursing Process: A Critical Thinking Approach*. (2nd ed.). Menlo Park, CA: Addison-Wesley.

This textbook integrates each step of the nursing process, considering concepts such as professional standards of care, nursing frameworks, ethical issues and wellness. Each chapter contains objectives as well as key terms. Critical thinking exercises assist in the development of this skill. The application activities contain an answer key with a rationale provided for the wrong answers.

Nutrition

Williams, S.R. (1999). *Essentials of nutrition and diet therapy* (7th ed.). St. Louis: Mosby.

This textbook uses color in tables, figures and photographs. It is easily readable and presents content in a sound and organized manner. Chapter openers help students focus on the topic covered. Chapter outlines, key terms, and chapter summaries help students identify important content. Each chapter includes questions to focus review of content. An interactive nutrient analysis CD-ROM accompanies the text.

Pediatrics

Wong, D. (1997). *Whaley and Wong's Essentials of pediatric nursing* (5th ed.). St. Louis: Mosby.
Please note: The 6th edition of this text will be available in October, 2000.

This textbook presents learning objectives for each chapter and contains many color photographs. Guidelines and emergency treatments are presented in boxes within each chapter. Hundreds of tables, boxes, and diagrams are used to highlight key concepts. Key points are summarized at the end of each chapter.

Study Guide:
Murphy, A. (1997). *Study guide to accompany Whaley and Wong's Essentials of pediatric nursing* (5th ed.). St. Louis: Mosby.

Pharmacology

Eisenhauer, L.A., Nichols, L.W., Spencer, R.T., & Bergan, F.W. (1999) *Clinical pharmacology and nursing management* (5th ed.). Philadelphia, PA: Lippincott.

This textbook incorporates essential pharmacological concepts, critical thinking activities, and clinical judgment skills so that drug therapy is as safe and appropriate as possible for patients and for nurses. Each chapter is organized beginning with an outline and review of physiology and pathophysiology as it relates to the drug class discussed. Key pharmacological content and nursing management links present the connection between drug theory and each step of the nursing process.

Student Workbook:
Eisenhauer et al. (1999). *Clinical pharmacology and nursing management.* (5th ed). Philadelphia: PA, Lippincott.

Additional Resources

The following resources are suggested to supplement your understanding of the material presented in the recommended resources. These resources include textbooks, journal articles, and Web resources. They were selected because they are current and relevant to the content to be tested by this examination. You are encouraged to read widely; you may find other textbooks, articles, or Web resources to be of interest. These additional resources are an important supplementary learning activity because they address issues that are of interest to practicing nurses and provide "real world" examples of how the theory in textbooks can be applied to actual clinical situations.

You should be able to find many of these resources at a nearby school of nursing library, college library, or hospital library. You might also find them at your state nurses' association library. In addition, your local public librarian may be able to assist you with an interlibrary loan request. It is not necessary to purchase these resources.

Textbook

Spector, R.E. (1996). *Cultural diversity in health and illness*. (4th ed.). Stanford, CT: Appleton & Lange.

This textbook is an excellent reference on cultural issues in nursing practice. In addition to a discussion on the needs of a multicultural society and the issues involved in the delivery of culturally sensitive nursing care, the text provides in-depth information on the traditional views of specific cultural groups with regard to health and illness.

Web Sites

American Pain Management Society: http://www.ampainsoc.org

American Sleep Disorders Association: http://www.asda.org

Chronic net: http://www.chronicnet.org/chronnet/project.htm

National Sleep Foundation Home Page: http://www.sleepfoundation.org

Journal Articles

Because journal articles tend to be written in a simple, straightforward manner, you may find them useful in explaining or expanding upon difficult concepts. Many articles include case studies or post-tests to help you assess your learning. You may also find them helpful in providing an "inside view" into areas of nursing practice with which you are not familiar. You may want to review nursing journals from this year to locate more current articles.

As a professional nurse, you have a responsibility to continue your education. One way you can keep current is by reading journal articles. Subscribing to one or two journals is a helpful way to gain exposure to current articles in the field.

I. Comfort and Pain

Acello, B. (2000). Meeting JCAHO standards for pain control. *Nursing 2000, 30*(3), 52–54.

Loeb, J.L. (1999). Pain management in long-term care. American *Journal of Nursing, 99*(2), 48–52.

Pasero, C. (1998). How aging affects pain management. *American Journal of Nursing, 98*(6), 12–13.

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VIII. Reproductive Disorders

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Content/Reference Chart

Listed below are the chapters in the recommended resources that cover the material in each content area. The list may help you begin to locate the topics in the content outline. The list is not intended to be comprehensive. To cover all of the material in this content guide, you will need to refer to other chapters in the reference textbooks. Chapter numbers and titles may differ in subsequent editions.

I. Comfort and Pain

Eisenhauer et al. (5th edition, 1998)
- Ch. 18 – Drugs that Depress the Central Nervous System
- Ch. 36 – Drugs that treat Inflammation (specifically the section on drugs used to reduce inflammation and pain)

Kozier et al. (6th edition, 2000)
- Ch. 43 – Pain Management

Wong, D. (5th edition, 1997)
- Ch. 6 – Communication and Health Assessment of the Health History of the Child and Family (specifically the section on performing a health history and analyzing a symptom: pain)
- Ch. 21 – Family Centered Care of the Child during Illness and Hospitalization (specifically section on pain assessment and management)

II. Human Sexuality

Dickason (3rd edition, 1998)
- Ch. 3 – Human Reproduction and Sexuality
- Ch. 5 – Fertility Care
- Ch. 6 – Infertility Care

Eisenhauer et al. (5th edition, 1998)
- Ch. 31 – Drugs that Affect Sexual Behavior and Reproduction (specifically sections on drugs that affect sexuality and drugs that prevent conception)

Kozier et al. (6th edition, 2000)
- Ch. 23 – Development from Conception Through Adolescence (specifically the section on adolescence)
- Ch. 24 – Development from Young through Older Adulthood

Olds et al. (6th edition, 2000)
- Part III– Human Reproduction (Chapter 6–8)

III. Cultural Diversity

Ayers et al. (1999)
- Ch. 11 – Special Populations in The Community

Dickason et al. (3rd edition, 1998)
- Ch. 2 – The Family in a Multicultural Society

Eisenhauer et al. (5th edition, 1998)
- Ch. 9 – Cultural Aspects of Drug Therapy

Kozier et al. (6th edition, 2000)
- Ch. 13 – Culture and Ethnicity
- Ch. 14 – Spirituality

Smeltzer & Bare (9th edition, 2000)
- Ch. 8 – Perspectives in Transcultural Nursing

Wong, (5th edition, 1997)
- Ch. 3 – Social, Cultural and Religious Influences on Child Health Promotion.

IV. Chronic Illness

Eisenhauer et al. (5th edition, 1998)
- Ch. 12 – Drug Therapy in Gerontological Nursing

Smeltzer & Bare (9th edition, 2000)
- Ch. 9 – Chronic Illness

Williams (7th edition 1999)
- Ch. 25 – Nutritional Support in Disabling Disease and Rehabilitation

Wong (5th edition, 1997)
- Ch. 18 – Impact of Chronic Illness, Disability or Death on the Child and Family

V. Community-Based Nursing

Ayers et al. (1999)
- Part I – Introduction to Community-Based Nursing (Chapters 1–3)
- Part II – Competencies and Tools for Community-Based Nursing (Chapters 4 and 5)
- Part IV – Issues and Trends in Community-Based Nursing (Chapters 12–13)

Eisenhauer et al. (5th edition, 1998)
- Ch. 13 – Drug Therapy in the Home and Community

Kozier et al. (6th edition, 2000)
- Ch. 7 – Community-Based Nursing and Care Continuity

Monahan & Neighbors (2nd edition, 2000)
- Ch. 2 – Medical-Surgical Nursing in Multiple Settings

Olds et al. (6th edition)
- Ch. 2 – Community-Based Teaching for Childbearing Families

Smeltzer & Bare (9th edition, 2000)
- Ch. 2 – Community-Based Nursing

Wong (5th edition, 1997)
- Ch. 18 – Impact of Chronic Illness, Disability or Death on the Child and Family (section on Helping Family Cope)

VI. Needs of the Childbearing Family

Ayers et al. (1999)
- Ch. 6 – Maternal-Infant Clients in the Community

Dickason et al. (3rd edition, 1998)
- Unit Two – Pregnancy (Chapters 8–12)
- Unit Three – Labor, Birth and Recovery (Chapters 13–17)
- Unit Four – Newborn Care (Chapters 18–20)
- Unit Five – Pregnancy at Risk (Chapter 21)

Eisenhauer et al. (5th edition, 1998)
- Ch. 10 – Drug Therapy in Maternal Care

Olds et al. (6th edition, 2000)
- Part Four – Pregnancy (Chapters 9–17)
- Part Five – Birth (Chapters 18–23)
- Part Six – The Newborn (Chapters 24–28)
- Part Seven – Postpartum (Chapters 30–33)

Williams (7th edition 1999)
- Ch. 11 – Nutrition During Pregnancy and Lactation
- Ch. 12 – Nutrition for Growth and Development

VII. Sensory Impairments

Monahan & Neighbors (2nd edition, 2000)
- Ch. 44 – Knowledge Base for Patients with Eye Dysfunction
- Ch. 45 – Nursing Care of Patients with Eye Disorders
- Ch. 46 – Knowledge Base for Patients with Ear Dysfunction
- Ch. 47 – Nursing Care of Patients with Ear Disorders

Smeltzer & Bare (9th edition, 2000)
- Ch. 54 – Assessment and Management of Patients with Eye and Vision Disorders
- Ch. 55 – Assessment and Management of Patients with Hearing and Balance Disorders

Wong (5th edition, 1997)
- Ch. 7 – Physical and Developmental Assessment of the Child (Section on auditory testing, and visual testing)
- Ch. 19 – Impact of Cognitive or Sensory Impairment on the Child and Family (specifically the section on sensory impairment
- Ch. 23 – The Child with Respiratory Dysfunction (section on Otitis Media)

VII. Sensory Impairments

Dickason (3rd edition, 1998)
- Ch. 4 – Women's Health Care (specifically the section from physical concerns to climacteric)

Eisenhauer et al. (5th edition, 1998)
- Ch. 31 – Drugs that Affect Sexual Behavior and Reproduction

Monahan & Neighbors (2nd edition, 1998)
- Ch. 38 – Knowledge Base for Men with Reproductive Dysfunction
- Ch. 39 – Nursing Care of Men with Reproductive Disorders
- Ch. 40 – Knowledge Base for Women with Reproductive Dysfunction
- Ch. 41 – Nursing Care of Women with Reproductive Disorders
- Ch. 42 – Nursing Care of Patients with Breast Disorders (up to the section on cancer)
- Ch. 43 – Nursing Care of Patients with Sexually Transmitted Diseases

Olds et al. (6th edition, 2000)
- Ch. 3 – Women's Health Care

Smeltzer & Bare (9th edition, 2000)
- Ch. 42 – Assessment and Management: Problems Related to Female Physiologic Processes
- Ch. 43 – Management of Patients with Female Reproductive Disorders
- Ch. 44 – Assessment and Management of Patients with Breast Disorders (omit section on malignant conditions)
- Ch. 45 – Assessment and Management: Problems Related to Male Reproductive Processes

Regents College Examination Development Committee in Nursing Concepts 3

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Key To Sample Questions

Question	Key	Content Area[1]	Question	Key	Content Area[1]
1	4	IA1	14	1	VIA1a1)
2	4	IA2	15	2	VIA7c
3	3	IB5a	16	3	VIA1b1)c)
4	3	IIA2a	17	1	VID5c
5	4	IIB1e	18	3	VIA1a2)
6	3	IIB2b	19	3	VIC1h
7	3	IIIA3c	20	4	VIC1h
8	4	IIIB2a	21	1	VIIA2
9	2	IVB1	22	2	VIIA2b
10	2	IVB3b	23	3	VIIB2a
11	2	VA2b	24	4	VIIIA3
12	2	VB5c	25	4	VIIIA6a
13	4	VB3a	26	1	VIIIB3b

[1]Content Area refers to the location of the question topic in the content outline.

Regents College Written Examinations

The following is a list of examinations scheduled to be offered during 2000–2001:

Arts and Sciences Examinations
Foundations of Gerontology
Pathophysiology
Psychology of Adulthood & Aging

Arts and Sciences Guided Learning Packages
Abnormal Psychology
American Dream
Anatomy & Physiology
English Composition
Ethics: Theory & Practice
History of Nazi Germany
Life Span Developmental Psychology
Microbiology
Religions of the World
Research Methods in Psychology
Statistics
World Population

Business Examinations
Business Policy & Strategy
Human Resource Management
Labor Relations
Organizational Behavior
Production/Operations Management

Education Examination
Reading Instruction in the Elementary School

Nursing Examinations
Associate Degree:
Differences in Nursing Care: Area A *(modified)*
Differences in Nursing Care: Area B
Differences in Nursing Care: Area C
Fundamentals of Nursing
Maternal & Child Nursing *(associate)*
Maternity Nursing
Nursing Concepts 1
Nursing Concepts 2
Nursing Concepts 3
Occupational Strategies in Nursing

Nursing Examinations
Baccalaureate Degree:
Adult Nursing
Health Restoration: Area I
Health Restoration: Area II
Health Support A: Health Promotion & Health Protection
Health Support B: Community Health Nursing
Maternal & Child Nursing *(baccalaureate)*
Professional Strategies in Nursing
Psychiatric/Mental Health Nursing

Nursing Guided Learning Package
Baccalaureate Degree:
Research in Nursing

To receive information concerning testing dates, locations, and fees, contact Regents College:

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